STATE MEDICAID P&T COMMITTEE MEETING

THURSDAY, September 17, 2010
7:00 a.m. to 8:30 a.m.
Cannon Health Building
Room 114

MINUTES

Committee Members Present:

Beth Johnson, R.Ph.
Michael Flynn, M.D.
Karen Gunning, PharmD.
Kort Delost, R.Ph.
Raymond Ward, M.D.
Lisa Hulbert, R.Ph.
Brandon Jennings, PharmD.
Ellie Brownstein, M.D

Dept. of Health/Div. of Health Care Financing Staff Present:

Robyn Seely, PharmD.
Jennifer Zeleny, CPhT, MPH
Tim Morley, R.Ph.
Richard Sorenson, R.N.

University of Utah Drug Information Center Staff Present:

Gary Oderda, PharmD.
Melissa Archer, PharmD.

Other Individuals Present:

Vern Stacey, GSK
Russell Frandsen, LFA
Trish McDaid-O'Neill, AstraZeneca
Scott Clegg, Lilly
Jenny Blackham, Lilly
Scott Brown, Teva
Mandy Hosford, AstraZeneca
Brett Brewer, EMD Serono
Tracy Davies, Lilly

Meeting conducted by: Karen Gunning, PharmD, Co-Chairperson.

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1. Review and Approval of Minutes: The minutes from August 2010 were reviewed. Beth Johnson moved to approve the minutes. Karen Gunning seconded the motion. The motion was approved unanimously by Beth Johnson, Karen Gunning, Ray Ward, Brandon Jennings, and Michael Flynn.

2. DUR Board Update: In September 2010, the DUR Board met and reviewed Multaq and Celebrex. In October the Board will consider, Xolair, Forteo, Stalero, and novel dosage forms.

3. Health Care Reform Update: Health Care Reform raised the level of minimum rebate percentage on brand name drugs, and the Feds will take the entire increase. In cases where rebates were already in excess of the minimum, the State will have to turn that over to the Federal Government. This will also be the case with some other classes of drugs, including line-extension drugs. This creates a liability for the State with line-extension drugs. In toto, the State will be keeping less of the rebates than in the past, and it will cost the state more to cover certain drugs. Utah will need to consider how to manage those drugs in order to keep the current prescription drug benefit. In

2014, there will be some different eligibility requirement and Medicaid rolls will increase. Medicaid is still trying to interpret all of the legislation, and the Feds are still trying to figure out how to calculate the new rebate levels. However, Medicaid is responsible for this as of January 1, 2010. CMS has not been able to provide current rebate data, and has sent some of the primary rebate information with null values. As a result, Medicaid has not been able to calculate certain primary rebates, or calculate PDL savings for lack of available information.

Karen Gunning asked if this legislation will incentivize generic use for Medicaid. Tim believed that it will incentivize generic drug usage, because the percentage that will go back to the Feds will be much smaller.

3. New Statin Update – Livalo: Melissa Archer, PharmD. of the University of Utah Pharmacotherapy Outcomes Research Center addressed the Committee and presented updated findings on the Statin class and new information on Livalo.

Jenny Blackham of Eli Lilly addressed the P&T Committee on the benefits of Livalo in patients with certain risk factors.

Karen Gunning clarified that there is still a contraindication for taking Livalo concomitantly with cyclosporine. Melissa Archer confirmed that this is the case.

Mandy Hosford with AstraZeneca addressed the P&T Committee on the label updates for Crestor that have come out since the Oregon Review.

Lisa Hulbert presented current utilization data in the Statin class to the P&T Committee. All strengths of the agents presented are preferred. The 2011 utilization data is due to the data being presented based on fiscal year. The State Fiscal Year 2011 started on July 1, 2010.

Dr. Ward noted that the generic utilization in this class is already quite high. This probably reflects the trends of commercial insurers to place PA's on branded agents in this class.

Karen stated that there is an opportunity to look at the class strategically if the class were divided into higher and lower potency statins, and based on drug interactions. Also there is an opportunity to look at individual agents based on strength. For example, if the utilization of Lipitor were primarily on the 40mg and 80mg strengths, that would be appropriate. However, generic agents could be used in place of the 10mg and 20mg.

Karen also clarified that most of the drug interactions with Statins are manageable, with the exception of certain narrow therapeutic index agents, such as cyclosporine. However, in those cases it may not be unreasonable to request that a PA be filled out. Same with the pediatric indications, since pediatric utilization in the class is rare.

Karen also stated that she was surprised to see that Oregon included ezetimibe combination products in the report. She felt that the ezetimibe-containing agent might need to be restricted by the DUR Board based on some of the data that has come out. Additionally, the Niacin/Statin combinations may need to be considered

as a separate class.

Dr. Flynn stated that the other P&T Committees that he has been on have considered Vytorin with the other high-potency Statins, but agreed that the drug should just go away.

Karen asked Melissa about the potency of pitavastatin. 1mg of pitavastatin is equivalent to 10mg atorvastatin and 20mg of simvastatin. It should be considered along those lines. It would not be considered a high-potency, and has been referred to as "moderate potency" in certain literature.

Dr. Flynn moved that pitavastatin is equally safe and effective as other lower potency Statins in the class. Brandon Jennings seconded the motion. The motion was approved unanimously by Beth Johnson, Karen Gunning, Ray Ward, Brandon Jennings, Kort DeLost, Beth Johnson, and Michael Flynn.

Karen Gunning moved that for patients requiring a large LDL reduction, Lipitor 40mg and 80mg, or Crestor 10-40mg should be included. Dr. Flynn seconded the motion. The motion was approved unanimously by Beth Johnson, Karen Gunning, Ray Ward, Brandon Jennings, Kort DeLost, Beth Johnson, and Michael Flynn.

Karen stated that given the low frequency of drug interactions and pediatric use, those issues can be handled by PA and do not require a separate motion. The Committee agreed with her.

Brandon Jennings moved that for moderately potent Statins, the PDL must include at least simvastatin, and may include pravastatin and/or pitavastatin. Karen seconded the motion. The motion was approved unanimously by Beth Johnson, Karen Gunning, Ray Ward, Brandon Jennings, Kort DeLost, Beth Johnson, and Michael Flynn.

Beth Johnson moved to support the utilization of generics where possible. Brandon Jennings seconded the motion. The motion was approved unanimously by Beth Johnson, Karen Gunning, Ray Ward, Brandon Jennings, Kort DeLost, Beth Johnson, and Michael Flynn.

4. Future Meeting Schedules: The next two meetings will be devoted to estrogen replacements for menopause. Dr. Brownstein requested that she receive materials sooner than the Monday afternoon before the meeting, because it is very difficult for her to review the material on such short notice. Dr. Oderda stated that his department is still attempting to catch up from the very short notice on which they took over the contract from the Drug Information Service. He will provide materials sooner in the future.

Melissa Archer asked for suggestions on how the Committee would like to receive information on the estrogens, as there have been many new entries into the class. Additionally, the topical versus oral categorization does not work well, because some topicals are local, and others are systemic. Karen Gunning suggested that the estrogens for menopause be divided into topical non-systemic and systemic (including topical and oral).

Next Meeting Set for Thursday, October 21, 2010
Meeting Adjourned.

Minutes prepared by Jennifer Zeleny